Health Insurance Marketplace

# Instructions to help you complete the Marketplace Eligibility Appeal Request

09/2017
Form Approved
OMB No. 0938-1213
Appeal Request Form – Individual D

## Use the right form to request an appeal

**Complete and mail the correct request form for your appeal.**

- Use this form in the following states:

| | | |
|---|---|---|
| Alabama | Montana | West Virginia |
| Alaska | New Jersey | Wyoming |
| Louisiana | Tennessee | |

- Visit **HealthCare.gov/marketplace-appeals** to:
  - Get an appeal request form for other states.
  - Learn more about Marketplace appeals.
- If you have an immediate need for health services and a delay could seriously jeopardize your health, you can ask for an expedited (faster) appeal review. (See Step 5).
- El formulario para apelar la elegibilidad del Mercado está disponible en español. Para más información visite, **CuidadoDeSalud.gov/es/marketplace-apeals**.
- To appeal Small Business Health Options Program (SHOP) eligibility, visit **HealthCare.gov/marketplace-appeals/shop-decisions**.

## Time frame to request an appeal

If you applied in one of the states listed above, you must submit your appeal request **within 90 days** of the date on the Marketplace eligibility determination notice that you're appealing.

## How to submit this form

Enter your information directly, then print your completed form. Or, print a blank form to fill in by hand using black or dark blue ink.

Sign the completed form and mail together with any supporting documents to:

**Health Insurance Marketplace**
**Attn: Appeals**
**465 Industrial Blvd.**
**London, KY 40750-0061**

You may also fax the form and documents to a secure fax line: **1-877-369-0130**.

You'll receive all future correspondence about this appeal from the Marketplace Appeals Center. The Marketplace Appeals Center is different from the Health Insurance Marketplace.

## What happens next?

1. We'll send you a notice letting you know that we received your appeal request. If there's a problem, like if it's missing information or we need clarification, we'll tell you what's missing and how you can provide additional information.
2. We'll review your appeal, including all documentation you have provided. We may contact you to request additional information or to discuss your appeal.
3. We may ask if you want to resolve your appeal informally. If you're satisfied with your informal resolution, you'll get an informal resolution decision in the mail.
4. If you're not satisfied with your informal resolution, you can ask us to schedule a hearing for your appeal. Most hearings are held over the phone. If you don't attend your hearing, your appeal will be dismissed.
5. After your hearing, you'll get a final appeal decision.

## Additional help

**Language assistance services**
If you need help with your appeal in a language other than English, you have the right to get information in your language at no cost. Call the Marketplace Appeals Center at 1-855-231-1751. Hours of operation are Monday through Friday, 7:00 a.m. to 8:30 p.m. Eastern Time (ET); and Saturday, 10:00 a.m. to 5:30 p.m. ET.

**Accessibility**
To request appeal forms and notices in an alternate format like braille, large print, data CD, audio CD, or to request a qualified reader, you can call the Marketplace Appeals Center at 1-855-231-1751. TTY users can call 1-855-739-2231. Hours of operation are Monday through Friday, 7:00 a.m. to 8:30 p.m. Eastern Time (ET); and Saturday, 10:00 a.m. to 5:30 p.m. ET. You can also make a request in writing by fax (1-877-360-0130) or mail (Marketplace Appeals Center, P.O. Box 311, Pittston, PA 18640). Accommodations are provided at no cost to you.
To submit your appeal request, see "How to submit this form" on page 1 of these instructions.

## Choose an authorized representative

You have the right to choose an authorized representative to help you with your appeal. This is a trusted person who has your permission to talk with us about your appeal, see your information, and act for you on matters related to your appeal, including getting information about you and signing your appeal request on your behalf.
To appoint an authorized representative, complete and mail the form "Appoint an authorized representative for my appeal," available at **HealthCare.gov/marketplace-appeals/getting-help**. You can also call the Marketplace Appeals Center to request this form. Even if you already completed an authorized representative form for your Marketplace application, you need to complete an additional form for your appeal.

## Questions

If your state isn't listed above, or to learn more about your appeal, call the Marketplace Appeals Center at 1-855-231-1751. TTY users can call 1-855-739-2231. Our hours of operation are Monday through Friday, 7:00 a.m. to 8:30 p.m. Eastern Time (ET) and Saturday, 10:00 a.m. to 5:30 p.m. ET.

**Paperwork Reduction Act Disclosure Statement**
According to the Paperwork Reduction Act of 1995 (PRA), no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1213. The time required to complete this information collection is estimated to average 1 hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ****CMS Disclaimer** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Marketplace Appeals Center.**

**Privacy and Use of Your Information**
The Marketplace protects the privacy and security of information about you that you've provided. To view the Privacy Act Statement, go to **HealthCare.gov/individual-privacy-act-statement**. We're authorized to collect the information on this form and any supporting documentation, including Social Security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111–152), implementing regulations in 45 CFR part 155, subpart F, and the Social Security Act. For more information about the privacy and security of your information, visit **HealthCare.gov/privacy**.

**Nondiscrimination**
The Health Insurance Marketplace doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age. If you think you've been discriminated against or treated unfairly for any of these reasons, you can file a complaint with the Department of Health and Human Services, Office for Civil Rights by calling 1-800-368-1019 (TTY: 1-800-537-7697), visiting **hhs.gov/ocr/civilrights/complaints**, or writing to the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201.

To help the Marketplace Appeals Center process your appeal, refer to the table below about the types of documents to submit with your appeal request. **Submit copies and not original documents, since your original documents won't be returned**. Write your first and last name on any documents you send with your appeal request.

You can send documents either:

**By mail**: Send your documents to this address:
Marketplace Appeals Center
P.O. Box 311
Pittston, PA 18640

**By fax**: Include a cover sheet with your first and last name, and fax your information to our secure fax line at 1-877-369-0129.

| Reason you are appealing | Examples of supporting documents to include with your appeal request |
|---|---|
| You lost financial assistance for your Marketplace coverage because the Marketplace told you that you didn't submit documents proving your household income. | • Tax returns (e.g. 1040, 1040A, 1040EZ)<br>• Pay stubs, W-2s, or 1099s<br>• Self-employment ledgers (including the name of the person earning the income, the company's name, the dates for which the income is received, and the net amount of profit or loss)<br>• Social security benefits statements |
| You lost financial assistance for your Marketplace coverage because the Marketplace told you that you didn't submit documents proving that you were ineligible for other types of health coverage. | • Medicaid – letter from your state's Medicaid agency or Children's Health Insurance Program (CHIP) stating you are not eligible for Medicaid or CHIP<br>• Department of Veterans Affairs (VA) – letter from VA stating you are not enrolled in health coverage<br>• Employer coverage (including COBRA) – letter from health insurance company or employer stating you were ineligible or showing termination information<br>• TRICARE – letter from Department of Defense Health Agency stating you are not eligible for health coverage<br>• Peace Corps – letter from Peace Corps stating you are not eligible for health coverage<br>• Medicare – letter from the Centers for Medicare & Medicaid Services (CMS) or Social Security Administration (SSA) stating you are not eligible for Medicare |
| You lost your coverage because the Marketplace told you that you didn't submit documents proving your citizenship or immigration status. | • Permanent Resident Card (I-551)<br>• Employment Authorization Card (I-766)<br>• United States and Unexpired Foreign Passports<br>• Driver's Licenses or State ID along with US Birth Certificate<br>• Notice of Action (I-797)<br>• Departure Record (I-94)<br>• Certificate of Citizenship (N-560/N-561)<br>• American Indian Card (I-872)<br>• School records showing the child's name and U.S. place of birth along with a school photograph ID |
| The Marketplace told you that you weren't eligible to enroll in or change plans through the Marketplace outside of an open enrollment period. | The reason you believe you should be allowed to enroll is because you:<br>• Lost or are losing coverage – letter from the insurance company, or the agency which administered the insurance, showing the last day of coverage<br>• Were denied Medicaid or Children's Health Insurance Program (CHIP) – denial or termination letter from your state's Medicaid agency<br>• Got married – marriage certificate, marriage license, or signed affidavit<br>• Had a baby, adopted a child, or placed a child for foster care – birth certificate, hospital records, adoption certificate, child support order, or court order<br>• Had a permanent move – driver's license, state ID, lease agreement, mortgage payment receipt, or utility bill |

Health Insurance Marketplace

# Marketplace Eligibility Appeal Request

**Enter your information directly, then print and sign your completed form. Or, print a blank form to fill in using black or dark blue ink. Use capital letters and fill in the circles (◯) like this → ● .**

09/2017
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## STEP 1: Tell us about the person who's requesting this appeal (also called the "appellant").

**1.First Name**

**Middle Name**

**Last Name**

**Date of Birth (mm/dd/yyyy)**

**Mailing Address**

**Apartment or suite number**

**City**

**State**

**ZIP code**

**Daytime phone number**

( ) –

**If other members of your household are appealing, write their names and dates of birth below.** Use extra paper, if necessary. Note: The outcome of an appeal could change the eligibility of other members of your household, even if they don't appeal their own eligibility determinations.

**2. First name**

**Middle Name**

**Last name**

**Date of birth (mm/dd/yyyy)**

**3. First name**

**Middle Name**

**Last name**

**Date of birth (mm/dd/yyyy)**

**4. First name**

**Middle Name**

**Last name**

**Date of birth (mm/dd/yyyy)**

## STEP 2: Electronic reminders.

**Do you want to get email or text message reminders and updates about your appeal from the Marketplace Appeals Center?** If so, please select preferred communication method (notifications will not contain personal health information).

Get appeal reminders by:

◯ **Text to mobile number**

**Mobile number**

( ) –

**The privacy policy can be found here:** healthcare.gov/privacy

◯ **Email (Remember to check your spam folder)**

**Email Address**

◯ **No reminders**

## STEP 3: Tell us why you're appealing.

**What's the date of the notice you are appealing? (mm/dd/yyyy)**

/ /

**What's the Application ID # (printed on the first page of the notice)?**

**Select each appeal reason that applies to you or someone in your household.**

◯ Marketplace determined that I wasn't eligible for coverage.

◯ I lost financial assistance for my Marketplace coverage, also called advance payments of the premium tax credit or cost-sharing reductions.

◯ I disagree with the amount of financial assistance (advance payments of the premium tax credit or cost-sharing reductions) that I was found eligible for.

◯ Marketplace determined that I wasn't eligible to enroll in or change plans through the Marketplace outside of an open enrollment period.

◯ Marketplace determined that I wasn't eligible for Medicaid or the Children's Health Insurance Program (CHIP). (Note: In your state, the Medicaid or CHIP program may have another name. Visit **HealthCare.gov/downloads/state-programs.pdf** for contact information and a list of state program names if you want to contact your state about your appeals process.)

- ◯ I would like to have my appeal of my denial of Medicaid eligibility heard by the Marketplace Appeals Center, which is the appeals entity for the Health Insurance Marketplace.
- ◯ I would like to have my appeal of my denial of Medicaid eligibility heard by my state Medicaid Agency. The Marketplace Appeals Center will forward this request to your state agency. (In Wyoming, contact Kid Care CHIP to appeal your eligibility for this program.)

◯ I applied for an exemption from the fee for not having health coverage and the Marketplace said that I did not qualify for an exemption.

◯ Marketplace didn't provide a timely eligibility determination after I applied for coverage.

Enter the date of your application, if available. (mm/dd/yyyy)

/ /

If you didn't select a reason for your appeal, please provide information about your appeal in Step 4.

## **STEP 4:** Tell us more about why you're requesting this appeal.

Use extra paper if necessary. If you're including documents to support your request, send us one copy of each of your documents. Keep all original documents.

## **STEP 5:** Ask for a faster appeal if you need one.

**If you have an immediate need for health services, and a delay could seriously jeopardize your life, health, or ability to attain, maintain, or retain maximum function, you can ask for an expedited (faster) appeal review.**

◯ **I need an expedited appeal.**

Explain the reason you need an expedited appeal. Write the reason for this request in the space below. Use extra paper if necessary. If you're including documents to support your request, send us one copy of each of your documents. Keep all original documents.

# STEP 6: Signature.

This information applies for all individuals signing below who are 18 or older.

**Your approval to let the Marketplace share federal tax information and Social Security Administration information for use during an appeal.**

During your appeal, we may need to share with you or your authorized representative the information the Marketplace used to determine your eligibility. This information might include employment income information from a consumer reporting agency, information about income you receive from the Social Security Administration, and federal tax information from the Internal Revenue Service about members of your household, including information from your last filed federal income tax return. The Marketplace can't share federal income tax information or monthly and annual Social Security Benefit information under Title II of the Social Security Act from the Social Security Administration to an authorized representative or other individuals without your consent. Sign below to give your consent.

I understand by completing, signing, and dating below, I authorize the Marketplace to disclose to the individuals whose signatures are provided below as well as any authorized representative any federal tax information in my eligibility record which was provided by the Internal Revenue Service. I also consent to the release by the Marketplace of my monthly and annual Social Security Benefit information under Title II of the Social Security Act to these same individuals along with other information in my Marketplace eligibility record, collected based on the application I filled out (or was completed for me) or that listed me as a household member, and from other data sources like income and employment verification from a consumer reporting agency that were used to make the Marketplace eligibility determination.

I understand I can request a copy of my Marketplace eligibility appeal record during the appeals process.

Each adult member of the household must consent to the disclosure of his or her own federal tax information and also consent to the release of monthly and annual Social Security Benefit information under Title II of the Social Security Act by signing below.

The authorization is valid until the earlier of:

- The resolution of the appeal; or
- My written notification that I want any or all of my authorized representatives removed from this appeal.

I'm signing this form under penalty of perjury, which means I've provided true answers to all the questions, and I've answered to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false information.

## Signature

**1. Printed name (First Name, Middle Name, Last Name)**

**Signature**

**Date (mm/dd/yyyy)**

## Signatures of everyone you listed in Section 1 who's 18 and older

**2. Printed name (First Name, Middle Name, Last Name)**

**Signature**

**Date (mm/dd/yyyy)**

**3. Printed name (First Name, Middle Name, Last Name)**

**Signature**

**Date (mm/dd/yyyy)**

## STEP 6: Signature (Continued).

This information applies for all individuals signing below who are 18 or older.

**4. Printed name (First Name, Middle Name, Last Name)**

**Signature**

**Date (mm/dd/yyyy)**

**Signatures of any other household members listed on the application for Marketplace coverage**

Even if they're not included in this appeal, each adult member of the household who's 18 and older must consent to the disclosure of his or her own federal tax information and also consent to the release of monthly and annual Social Security Benefit information under Title II of the Social Security Act by signing below.

**5. Printed name (First Name, Middle Name, Last Name)**

**Signature**

**Date (mm/dd/yyyy)**

**6. Printed name (First Name, Middle Name, Last Name)**

**Signature**

**Date (mm/dd/yyyy)**

**7. Printed name (First Name, Middle Name, Last Name)**

**Signature**

**Date (mm/dd/yyyy)**

**8. Printed name (First Name, Middle Name, Last Name)**

**Signature**

**Date (mm/dd/yyyy)**